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No. 93-507

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

ADMINISTRATORS OF THE TULANE EDUCATIONAL FUND d/b/a/ TULANE MEDICAL CENTER HOSPITAL AND CLINIC, *et al.*,

Petitioners,

v.

DONNA E. SHALALA, Secretary
Department of Health and Human Services,

Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The District Of Columbia Circuit

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PETITIONERS' REPLY TO BRIEF IN OPPOSITION

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The Secretary's Brief in Opposition is marked by misrepresentation, inconsistency, and evasion. Before the court of appeals, the Secretary made very strong representations regarding the importance and urgency of definitively resolving the issue in this case as expeditiously as possible. Astonishingly, without any attempt to explain her prior inconsistent representations, the Secretary now attempts to minimize the importance of the issue. Moreover, the Secretary, for the first time, makes the patently bogus argument that certain recoupment provisions in the Omnibus Budget Reconciliation Act of 1990 reflect congressional approval of the reaudit regulation. In fact, the cited provisions in no way evidence even congressional awareness, much less approval, of the reaudit regulation and would have been necessary under either the Secretary's

or petitioners' construction of the graduate medical education ("GME") statute.

With respect to the merits, the Secretary's brief is more important for what it does not say than for what it says. Specifically, the Secretary (1) has not denied (as she cannot) that her interpretation of the relevant words in 42 U.S.C. § 1395ww(h)(2)(A) is in direct conflict with her interpretation of the virtually identical words in section 1395ww(a)(1)(C) and section 1395ww(b)(3)(A)(i) (Petition for a Writ of Certiorari ("Pet.") at 15-17); (2) has not attempted to explain why the GME statute conspicuously omits any authorization for the Secretary to redetermine the numerator in the GME formula (the 1984 GME cost amount) when it expressly confers extensive authority for the Secretary to determine the denominator (the resident count) (Pet. at 13-14, 26-27); (3) has not disputed that her construction of the statute necessitates the abrogation of established principles of res judicata and collateral estoppel (Pet. at 20-21); (4) has not offered any explanation for why Congress would possibly have intended that the Secretary use the same "reasonable cost" principles to reach separate and inconsistent determinations of 1984 GME costs when the Secretary had ample time to make a single determination applicable to both 1984 and the per resident amount methodology (Pet. at 23-25); and (5) has not addressed how a 1991 reaudit of 1984 costs, conducted long after the reopening and record-retention periods for 1984 had expired, could reasonably be expected to produce a more accurate result than the audit completed in 1985 or 1986 (Pet. at 19-20).

Significantly, the Secretary readily acknowledges that the reaudit determination does not apply to 1984 and in many cases was based not on 1984 data, but on data for years after 1984. Brief for the Respondent in Opposition ("Opp. Br.") at 13 & n.5. These admissions demonstrate the clear conflict of the reaudit regulation with the statute, which requires that the Secretary compute an "average"

based on "the amount recognized as reasonable under this subchapter" for 1984.

ARGUMENT

1. Petitioners and the two amici (the American Hospital Association and the Association of American Medical Colleges) have represented that the issue raised in this case is of great importance to the nation's hospitals and that if certiorari is denied, the issue will undoubtedly be raised in numerous court cases around the country. The Secretary characterizes this representation as "highly speculative," noting that to date only a few court cases have been brought on this issue, all of which have been filed in the District of Columbia. Opp. Br. at 16-17. The facts demonstrate that petitioners' and amici's representations are not speculative at all.

All hospitals (except those located in the District of Columbia) have a choice of forum in Medicare cases. They may file suit either in the U.S. District Court for the District of Columbia or in the U.S. District Court for the judicial district in which they are located. 42 U.S.C. § 1395oo(f)(1). Once one hospital has instituted suit on a particular issue in the District of Columbia, many hospitals that have filed administrative appeals for the issue naturally believe that it is strategically prudent to await the outcome of the District of Columbia suit before instituting their own court suit. If the District of Columbia suit is successful, they can file suit in the District of Columbia and take advantage of the favorable precedent already established for that circuit. If the District of Columbia suit is unsuccessful, they can file suit in the district court for the judicial district in which they are located. Thus, since the first suit on this issue was brought in the District of Columbia, it is not surprising that to date only a few hospitals have raised this issue in court.

Even the few cases brought so far, however, demonstrate how easy it would be to raise this issue in all eleven

remaining circuits. Petitioner Fairfax Hospital (located in Virginia) could have filed suit in a district court in the Fourth Circuit; petitioner Tulane Medical Center (located in Louisiana) could have filed in a district court in the Fifth Circuit; and petitioner Methodist Hospitals of Memphis (located in Tennessee) could have filed in a district court in the Sixth Circuit. Moreover, the four suits filed in the U.S. District Court for the District of Columbia after the district court decision but before the court of appeals decision in this case (Opp. Br. at 17 n.8) could have been filed in federal district courts located in the Third, Ninth, Tenth, and Eleventh Circuits.[1] Thus, the eleven hospitals that have brought suit so far could have instituted suit in a total of eight different federal circuits.

The amici briefs eloquently demonstrate how strongly hospitals feel about the issue raised by petitioners. Moreover, they (along with the petition itself) demonstrate the cogency of the hospitals' position on this issue. Should this Court deny certiorari, the many hospitals that have deferred bringing a court suit on this issue pending the final outcome of this suit will begin to act—the floodgates, so to speak, will be opened. Ultimately, the majority of the hospitals in the 504 appeals pending before the Provider Reimbursement Review Board ("PRRB") will likely file a court suit on this issue, but far fewer than that will be

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[1] The plaintiff in *Mount Sinai Medical Center of Greater Miami, Inc. v. Shalala*, No. 92-1963-GHR (D.D.C.), is located in Florida and could have filed suit in a court in the Eleventh Circuit. The plaintiff in *Reading Hospital and Medical Center v. Shalala*, No. 92-2824-TPJ (D.D.C.), is located in Pennsylvania and could have filed suit in a court in the Third Circuit. The two plaintiffs in *Emanuel Hospital and Health Center, et al. v. Shalala*, No. 92-2876-SS (D.D.C.), are located in Oregon and could have filed suit in a court in the Ninth Circuit. The plaintiff in *P/SL Healthcare System v. Shalala*, No. 93-0410-LFO (D.D.C.), is located in Colorado and could have filed suit in a court in the Tenth Circuit.

required to ensure litigation of this issue in all circuits.[2] Indeed, as the foregoing analysis regarding the eleven hospitals that have filed suit on this issue in the District of Columbia shows, litigation of this issue would be likely in all remaining eleven circuits even if only 3 to 5% of the hospitals with pending PRRB appeals elect to bring a court suit on the issue. Given the strength of the hospitals' position, a conflict between the circuits is inevitable.

Meanwhile, litigation of the merits of the reaudit adjustments will proceed before the PRRB and will eventually reach the federal courts.[3] All the scores of man-years devoted to that effort will be entirely wasted if this Court ultimately decides (after the development of a conflict) that, as petitioners contend, the Secretary lacked the authority to reaudit closed 1984 cost reporting years.[4] Thus, not only is the issue raised by petitioners of exceptional importance, but it is also of exceptional importance that the issue be definitively resolved as soon as possible.[5]

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[2] Petitioners are not in a position to confirm or refute the Secretary's undocumented allegations regarding the number of settlements that have occurred. However, the Secretary's allegations do not affect the accuracy of the figure (504) cited by petitioners as the number of pending GME cases. That figure represents not the number of GME cases originally filed with the PRRB, but the number that, according to the PRRB's response to petitioners' Freedom of Information Act request, were pending as of August 26, 1993.

[3] Petitioners do not share the Secretary's optimism that a substantial percentage of the pending cases may be settled. However, even assuming *arguendo* settlement of half the cases, that would still leave over 250 cases to be litigated. The difficulties involved in litigating in the mid- to late 1990s (and into the next century) the merits of reaudit adjustments for closed 1984 years would be enormous.

[4] The amici have discussed at length why the issue raised is of such extraordinary national importance that it warrants this Court's immediate review. *See* Brief of American Hospital Association at 2, 9-16; Brief of Association of American Medical Colleges at 2-7. Petitioners fully subscribe to the considerations advanced by the amici.

[5] The Secretary's current attempt to minimize the significance of this

2. The Secretary contends that certain provisions in the Omnibus Budget Reconciliation Act of 1990 ("OBRA 1990") regarding the recoupment of overpayments for GME costs reflect congressional approval of the reaudit regulation. Opp. Br. at 15-16. This is a blatant misrepresentation.

The GME statute was enacted in April 1986, effective for cost reporting years beginning on or after July 1, 1985. However, by 1990, when Congress enacted the cited OBRA 1990 provisions, the Secretary still had not implemented the per resident amount methodology for *any* years. Instead, she had continued to reimburse hospitals under traditional "reasonable cost" principles with the intent of eventually reopening the years and applying the per resident amount methodology.

Congress enacted the OBRA 1990 amendments in response to concerns raised by teaching hospitals and hospital associations regarding the effect on hospital cash flow if the Secretary attempted to recoup all "alleged overpayments" for many prior years at one time. The amendments precluded the Secretary from beginning recoupment prior to October 1, 1991, and from recouping more than 25% of the "alleged overpayments" for the prior years in a particular fiscal year. The non-judgmental nature of Congress' action is evident from its reference to the recoupment of "*alleged* overpayments." OBRA 1990, § 4004(a)(1) (emphasis added). The amendments were needed regardless of whether the Secretary used the actual 1984 amount or the reaudited 1984 amount to implement the statute.[6]

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case is truly astonishing given her representations before the court of appeals regarding the urgency and the impact of this issue. *See* Pet. at 9 and Brief of Amicus American Hospital Association at 9. Apparently the Secretary believes that the issue is of great significance when she loses, but is of only minor significance when she wins.

[6] Several aspects of the GME statute were intended to reduce the amount paid for GME costs so that payment was generally lower than

The cited OBRA 1990 amendments in no way support the Secretary's position in this case. Petitioners are challenging the validity of the Secretary's interpretation of a particular provision of the GME statute. They are not suggesting that the GME statute should not be implemented. In the cited amendments, Congress was simply preventing the Secretary from recouping in a disruptive manner, a proposition with which petitioners obviously have no quarrel.

3. The Secretary suggests that her interpretation of the words "amount recognized as reasonable under this subchapter" in the GME statute focuses on substantive standards, while petitioners' focuses on process. Opp. Br. at 11. The Secretary draws a false dichotomy between process and substantive standards. The process relied on by petitioners is the one mandated by Congress to establish the amount recognized as allowable *under the substantive "reasonable cost" reimbursement standards* for each cost reporting year. Pet. at 12-13. The Secretary also relies on a process to establish a redetermination of that amount, but it is an administratively-created process created out of whole cloth without any congressional authorization. *Id.* at 13-14.

The Secretary's construction cannot be reconciled with, among other things, Congress' use of the past tense ("recognized"). That tense makes perfect sense under petitioners' "plain meaning" construction: The 1984 year precedes the years payable under the new methodology, and thus the final 1984 amount is recognized in the normal course before final payments are due for the later years.

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under "reasonable cost" principles. For instance, the new system established tight inflation limits for each year. 42 U.S.C. § 1395ww(h)(2)(B)-(D). It also limited hospitals to the inflated 1984 per resident amount rate even if they introduced new specialties after 1984 that were more sophisticated and costly than their 1984 specialties. *See* 54 Fed. Reg. 40,308-310 (1989).

However, the past tense makes absolutely no sense if, as the Secretary contends, Congress intended the Secretary to use as the numerator in the per resident amount formula not the amount actually recognized for 1984, but a new 1984 amount "to be recognized" solely for the per resident amount methodology.

4. The reaudit regulation has required the Secretary, in a large number of cases, to rely on post-1984 data to establish 1984 costs for the GME per resident amount methodology. *See* Pet. at 17-18; Brief of American Hospital Association at 6-7. The Secretary responds that this fact is irrelevant to determining the validity of her regulation. Opp. Br. at 13-14 n.5.

The Secretary's response is nonsensical. Congress directed that 1984 be used as the base year. It is hard to imagine a plainer violation of the statutory mandate than a regulation which admittedly requires use of data from another year to establish the 1984 amount.

5. The Secretary contends that the three-year reopening standard was established by regulation and that she is therefore entitled to extend the reopening period by regulation. Opp. Br. at 12. She argues that she could have applied the reaudit amount directly to 1984, and that she acted modestly by limiting application to the per resident amount methodology. *Id.*

The Secretary clearly misconceives the scope of her authority. It is not at all clear that the Secretary could extend the three-year reopening period even were she to act prospectively,[7] but that is not what occurred.

The Secretary issued the reaudit regulation after the reopening and record-retention periods for 1984 had ex-

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[7] The Secretary's three-year reopening standard is itself a very expansive reading of her power under the Medicare statute, which does not confer any express reopening authority on the Secretary.

pired. Obviously under those circumstances she could not have applied the reaudit determination directly to 1984. Such a retroactive extension of an already expired reopening period would clearly constitute impermissible retroactive rulemaking under *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988).

The retroactivity problem is not lessened by limiting application of the reaudit regulation to the per resident amount methodology. The reopening standard applies not just to a particular determination, but to "findings at issue" in that determination. 42 C.F.R. § 405.1885(a). The 1984 reaudit determination has *retroactively* rejected "findings" made for 1984 that were already "final and binding." *See* 42 C.F.R. § 405.1807. Thus, viewed as a modification to the Secretary's reopening standards (as the Secretary suggests), the reaudit regulation is clearly an impermissible retroactive rule under *Georgetown*.

6. The Secretary contends that the reaudit regulation is not inconsistent with principles of fairness and repose because it does not apply directly to the closed 1984 year, but applies only to subsequent years that are still open. Opp. Br. at 13. The Secretary's argument is absurd.

Under the statute, 1988 GME costs are not relevant to 1988 GME payments, nor are 1991 GME costs relevant to 1991 GME payments. The relevant GME costs for all years are those incurred in 1984. Thus, since the only relevant audit is an audit of 1984, the relevant reopening standards are those applicable to 1984.

The Secretary's logic would allow the Secretary to reopen a hospital's 1984 cost report in the year 2003 to redetermine 1984 costs for the per resident amount used in 2000 because the 2000 cost report would still be open in 2003. A hospital's 1984 year would be forever subject to reaudit, and the Secretary could, over the years, make numerous separate and inconsistent determinations of 1984

costs. A position more incompatible with principles of fairness and repose would be hard to imagine.

CONCLUSION

For the foregoing reasons and for the reasons stated in the petition and in the briefs filed by the amici, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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